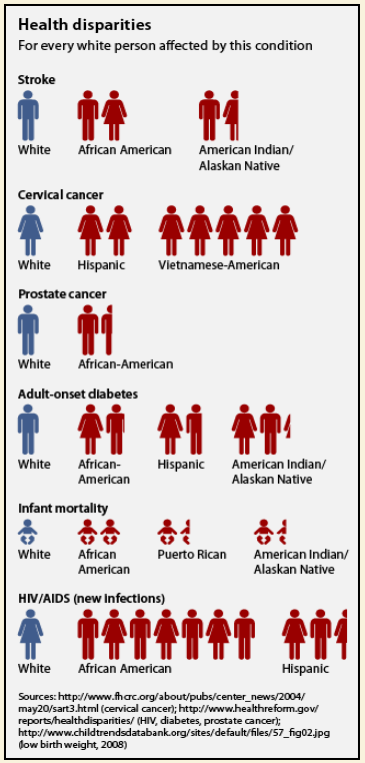
SAMHSA-HRSA
Center for Integrated Health Solutions

Identifying and Addressing Health Disparities in your PBHCI Program

What are health disparities?

"Population-specific differences in the presence of disease, health outcomes, or access to health care."

- Health Resources and Services Administration



Why care about health disparities?

- Disparities negatively affect the quality of life for affected populations
- Disparities cost money
- Addressing disparities may be a requirement of your PBHCI grant agreement
  - Impact statement
  - Implementation plan (including how to review data for health outcomes)
  - Policies and procedures that comply with CLAS standards

It's easy to develop a PDSA cycle for tracking health and wellness interventions

- Plan
  - Identify needs of subsets in your population
  - Identify disparities in outcomes
- Do
  - Provide culturally sensitive interventions
- Study
  - Review outcomes after implementing new interventions
- Act
  - Use new data to determine next course of action

Leveraging HIT

(1) automate and standardize the collection of race/ethnicity and language data,

(2) prioritize the use of the data for identifying disparities and tailoring improvement efforts,

(3) focus HIT efforts to address fragmented care delivery for racial/ethnic minorities and limited-English-proficiency patients,

(4) develop focused computerized clinical decision support systems for clinical areas with significant disparities,

(5) include input from racial/ethnic minorities and those with limited English proficiency in developing patient HIT tools to address the digital divide.

Source: Bridging the Digital Divide in Health Care: The Role of Health Information Technology in Addressing Racial and Ethnic Disparities. 2011 *The Joint Commission Journal on Quality and Patient Safety*

EHR Adoption

- Providers who cared for black & Hispanic patients who did not have insurance or with Medicaid coverage were 12% to 36% less likely to use EHRs than providers with privately insured non-Hispanic white patients.

- In addition, FQHCs with high rates of uninsured patients were 47% less likely to adopt EHRs.

Population Based Care/Health Management

Strategies for optimizing the health of an entire client population by systematically assessing tracking, and managing the group's health conditions and treatment response. It also entails approaches to engaging the entire target group, rather than just responding to the clients that actively seek care.

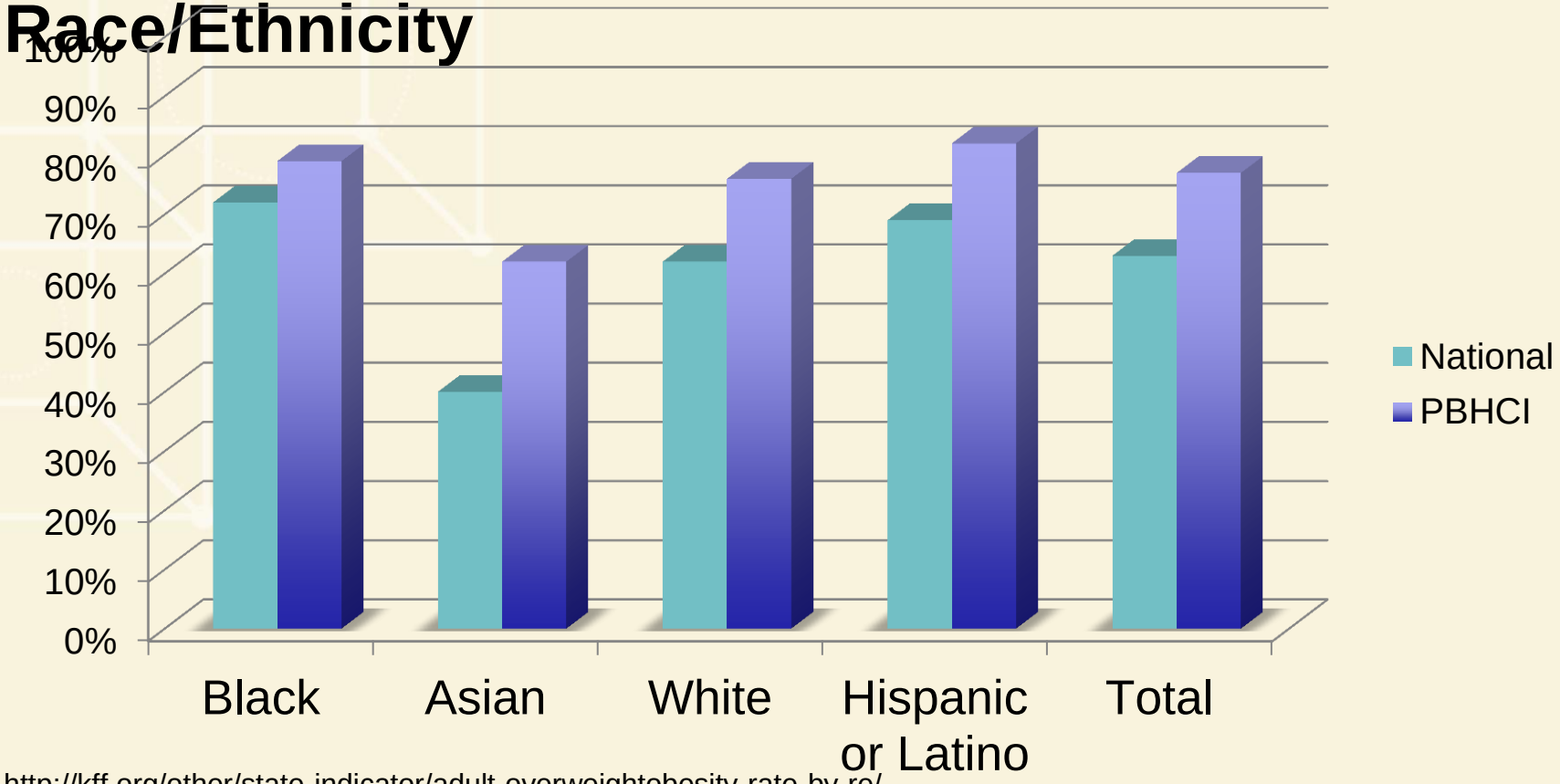
Patient Registry

"…an organized system to collect uniform data (clinical and other) to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure, and that serves one or more predetermined scientific, clinical, or policy purposes."

Gliklich RE, Dreyer NA, eds. (2010).
Registries for Evaluating Patient Outcomes: A User's Guide. 2nd ed.

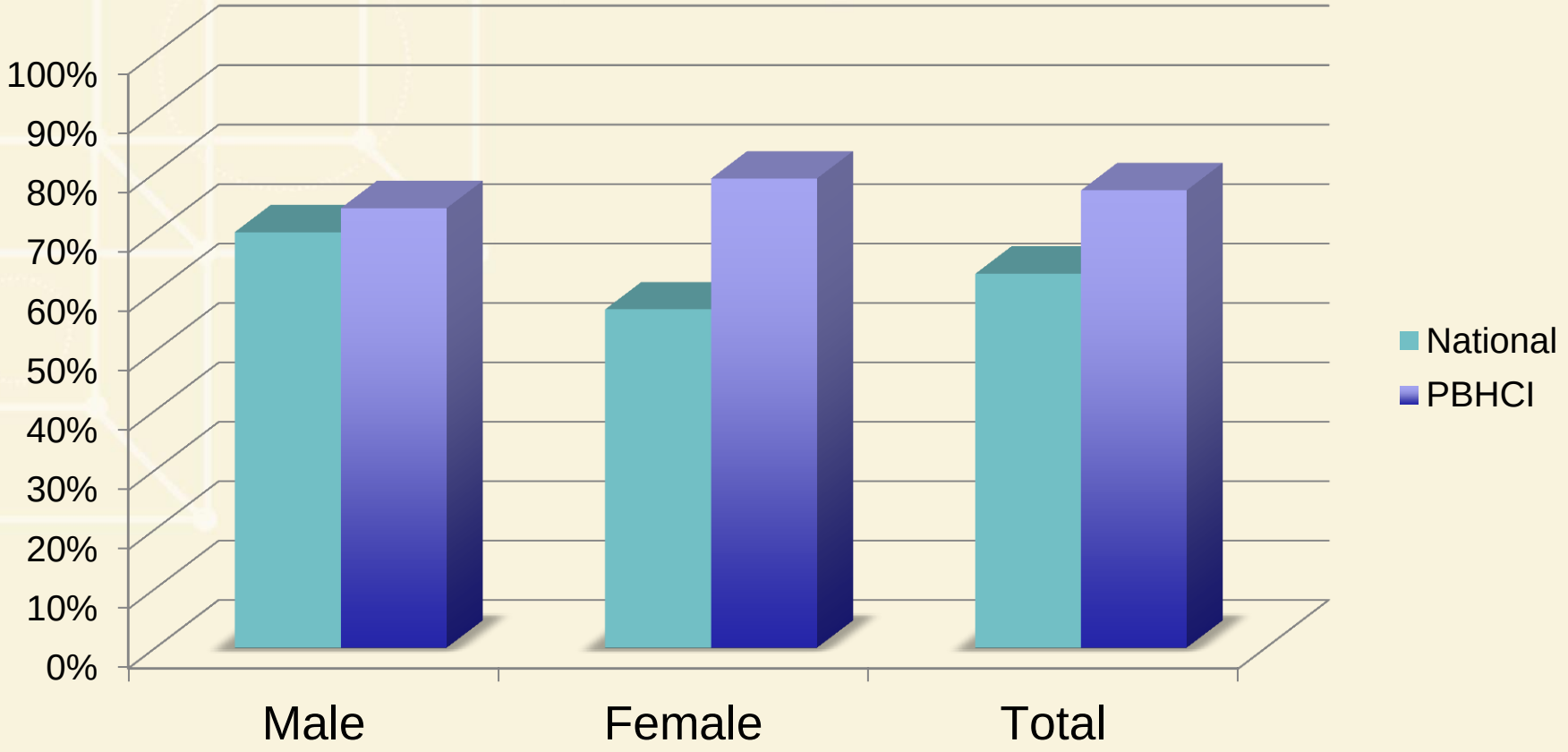
IDENTIFY NEEDS AND CURRENT OUTCOMES OF POPULATION SUBSETS

Incidence of Obesity (BMI>25) by Race/Ethnicity



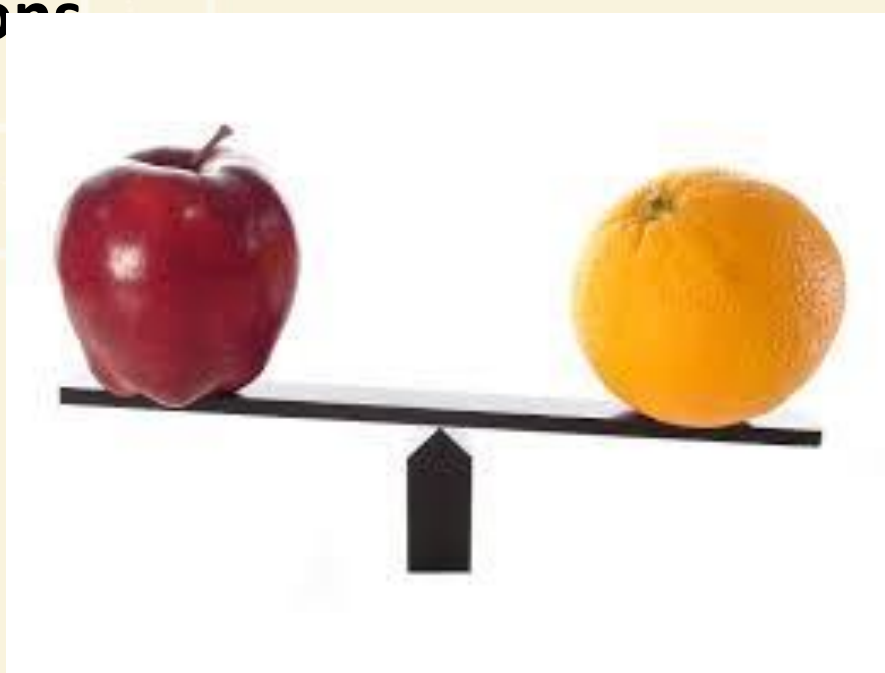
http://kff.org/other/state-indicator/adult-overweightobesity-rate-by-re/

Incidence of Obesity (BMI>25) by Gender

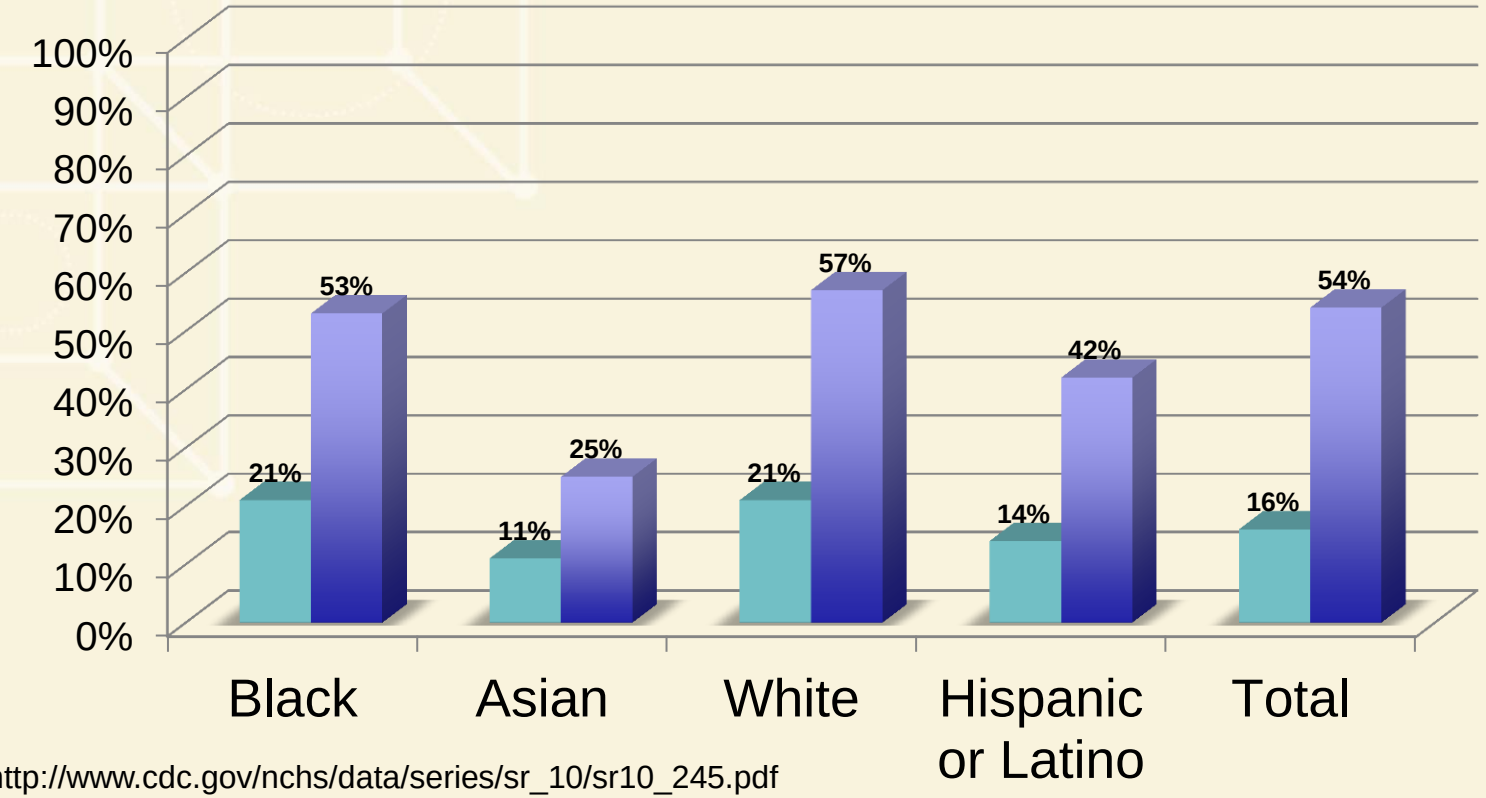


http://kff.org/other/state-indicator/adult-overweightobesity-rate-by-re/

To the extent possible, try to make honest comparisons

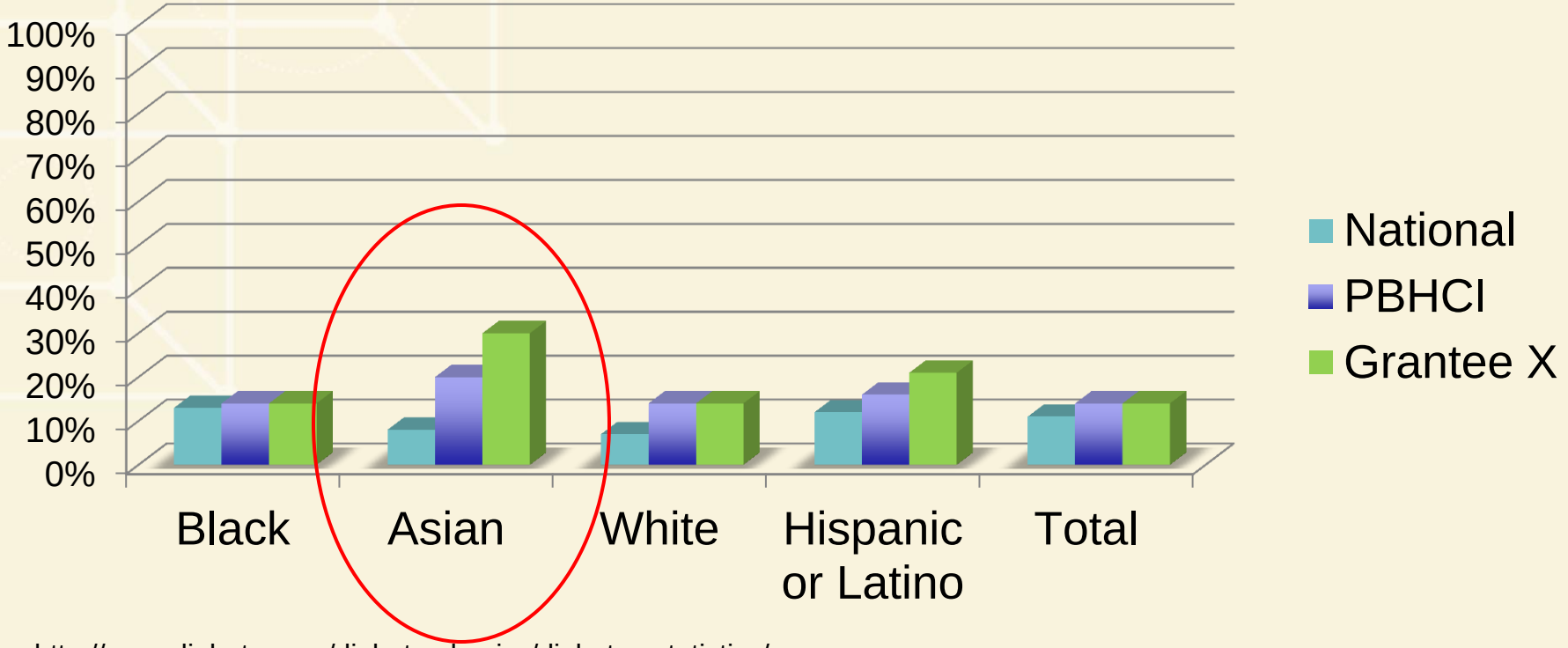


Incidence of Smoking (daily smoker) by Race/Ethnicity



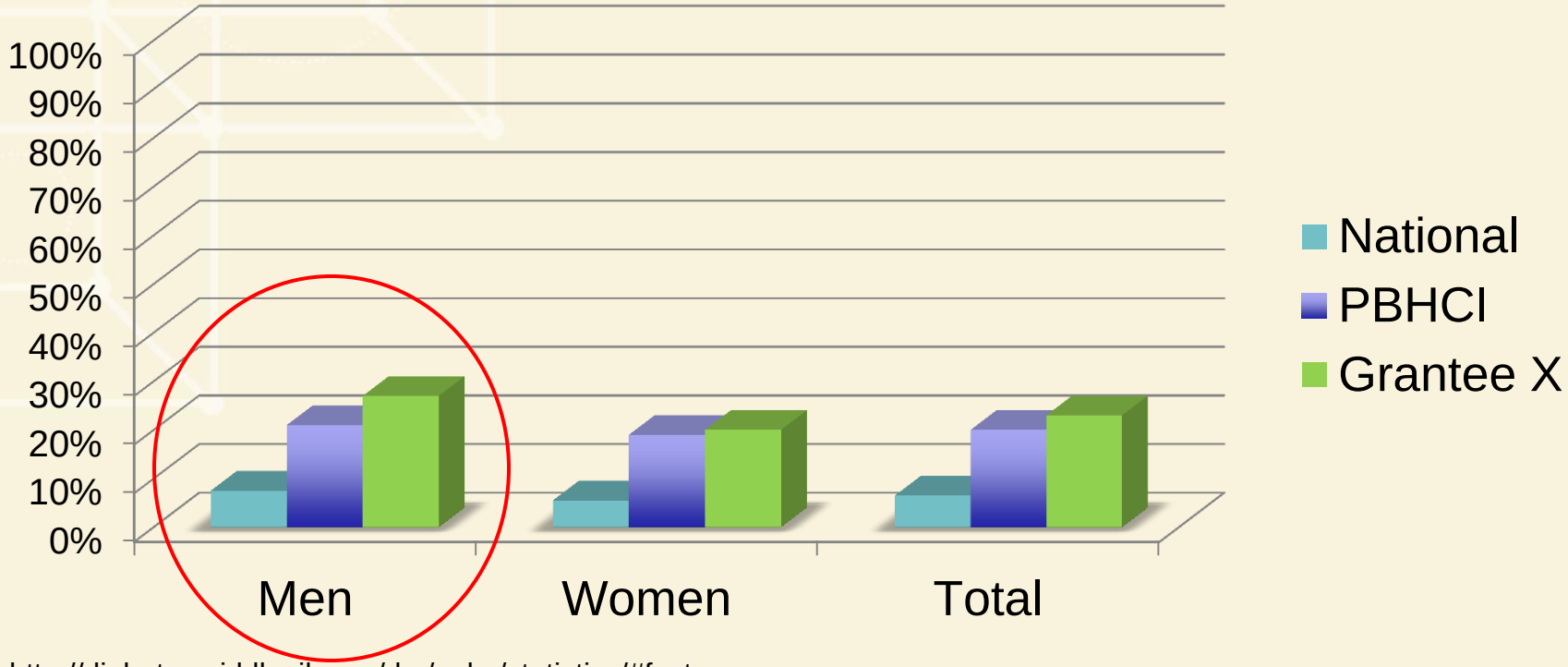
http://www.cdc.gov/nchs/data/series/sr_10/sr10_245.pdf

Incidence of Diabetes (FBG>126) by Race/Ethnicity



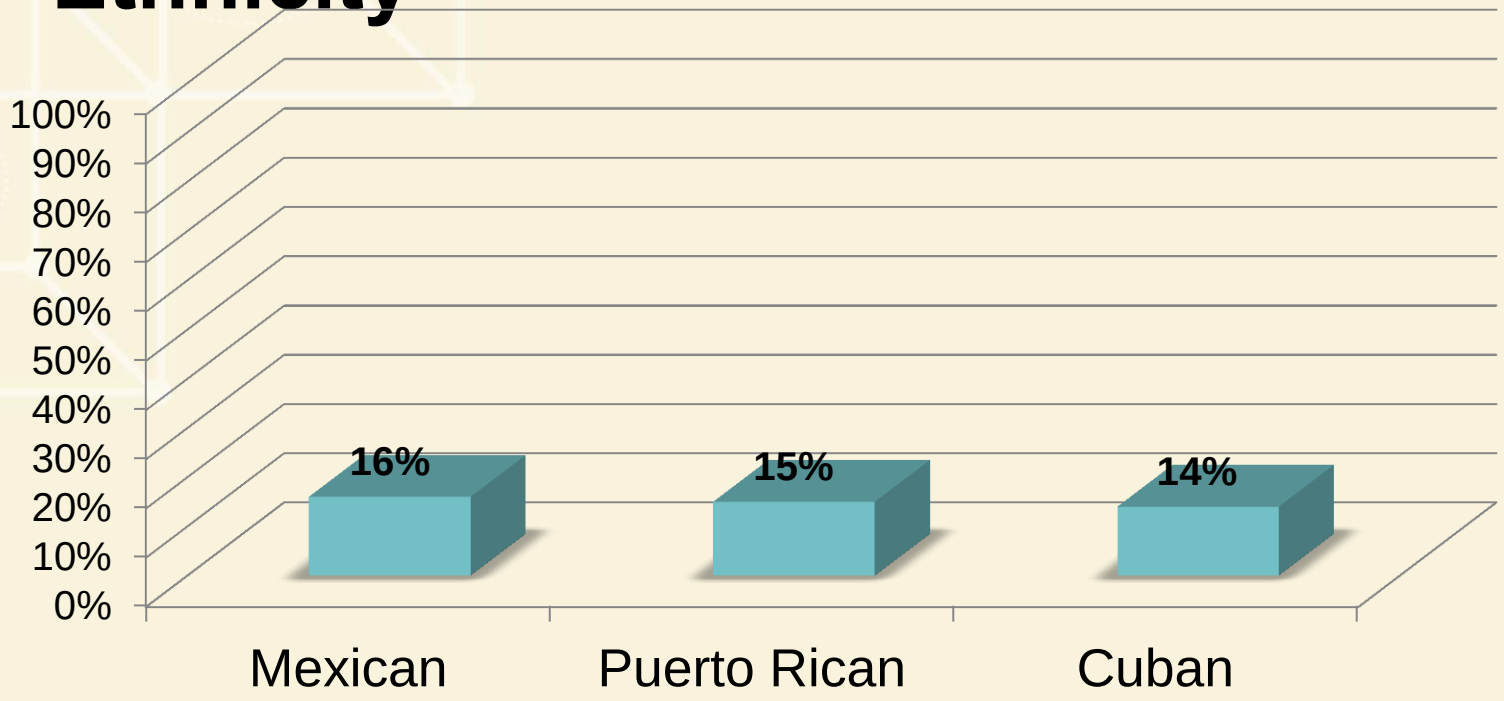
http://www.diabetes.org/diabetes-basics/diabetes-statistics/

Incidence of Diabetes Among Asian Population by Gender



http://diabetes.niddk.nih.gov/dm/pubs/statistics/#fast

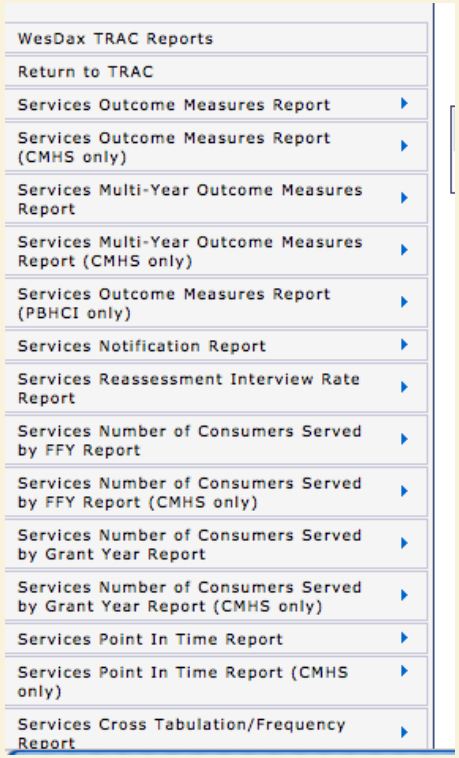
Aggregate PBHCI Incidence of Diabetes Among Hispanic/Latino Population by Ethnicity



You can obtain prevalence and outcomes data for your population from two sources:

- TRAC
- Patient Health Registry

Select the *Services Outcome Measures (PBHCI only)* Report in TRAC



Select all relevant demographic filters

- ❑ Gender
  - ❑ Female
  - ❑ Male
- ❑ Ethnicity
  - ❑ Hispanic/Latino
  - ❑ Not Hispanic/Latino
- ❑ Race
  - ❑ African-American
  - ❑ Asian/Pacific Islander
  - ❑ White

Race & Ethnicity in TRAC

- Ethnicity is only entered in TRAC if an individual identifies as Hispanic/Latino. Ethnicity categories are:
  - Central American
  - Cuban
  - Dominican
  - Mexican
  - Puerto Rican
  - South American
  - Other (specify)
  - Multi-Ethnic

- Race is entered for all consumers

Observe prevalence and improvement data

Services Outcome Measures (PBHCI only)

Section H Indicator	Number of Valid Cases	At-risk at Baseline	At-risk at Second Interview	Outcome Improved
Blood Pressure - Systolic	360	32.5 %	33.9 %	17.8 %
Blood Pressure - Diastolic	360	21.9 %	22.8 %	11.7 %
Blood Pressure - Combined	360	38.9 %	39.4 %	18.9 %
BMI	349	63.6 %	61.3 %	53.6 %
Waist Circumference	248	67.7 %	62.5 %	52.8 %
Breath CO	200	7.5 %	10.5 %	5.0 %
Plasma Glucose (fasting)	75	38.7 %	38.7 %	41.3 %

If you have a patient registry, does it track all relevant demographic information?

- ❑ Age
- ❑ Gender
- ❑ LGBT status
- ❑ Ethnicity
- ❑ Race
- ❑ Primary Language

Remember to engage with your evaluation team early in the process

- Create an evaluation plan (including timeline)
- Who will collect data?
- How will you define success?

PROVIDE CULTURALLY SENSITIVE INTERVENTIONS

Find an intervention that is appropriate for your target audience

Resources

- Integration.samhsa.gov
- HHS Office of Minority Health
- CDC Office of Minority Health and Health Disparities
- National Institute on Minority Health and Health Disparities
- Websites for specific health conditions (diabetes.org)
- ACA guidance on collecting granular data
- National Network to Eliminate Health Disparities in Behavioral Health (NNED)

Also consider policy and system interventions

Examples:

- Healthy food options offered to clients / in vending machines
- Referral system in place to community-based resources that focus on population subset
- Staffing

REVIEW OUTCOMES AFTER IMPLEMENTING NEW INTERVENTIONS

"Hello, evaluator? Have our outcomes improved?"

USE NEW DATA TO DETERMINE NEXT COURSE OF ACTION

How to Act

- Meet as a team to review the data.
- If the new intervention provided improved health outcomes, you might not want to make a change
- If the new intervention did not improve health outcomes, consider new interventions

Upcoming TA Opportunities

Health Disparities Small Working Groups

- Wednesday, March 26
- Wednesday, May 28
- Wednesday, July 23
- Wednesday, September 24